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STATEMENT
of
Assure Holdings, LLC

to the

U.S. House of Representatives
Committee on Ways & Means
Subcommittee on Health

Re: Protecting Patients from Surprise Medical Bills

Statement made by Paul Webster
Vice President of Strategy at Assure Holdings Corp.

May 28, 2019

Chairman Doggett, Ranking Member Nunes, and members of the subcommittee, I am Paul Webster, vice president of strategy at Assure Holdings, LLC (ARHH). ARHH is a national provider of intraoperative neuromonitoring services (IONM) for patients undergoing invasive surgical procedures that involve the nervous system, directly, indirectly or inherently places neural structures at risk. The goal of IONM is to identify changes in brain, spinal cord, and/or peripheral nerve function in order to prevent complications that could result in irreversible nerve damage.

We appreciate the opportunity to provide testimony to the U.S. House of Representatives Committee on Ways and Means Health Subcommittee as part of the hearing titled, “Protecting Patients from Surprise Medical Bills”. We share a common interest in safeguarding patient access to healthcare while keeping access affordable for patients.

Covering the Cost of Care

Isolating the cost of providing care to an individual patient is complex and varies widely depending on many factors. Direct costs for care include clinical wages, benefits, equipment, supplies, facility, and the duration of care. Indirect costs include training, travel, administrative overhead, and unrecovered losses from underpaid and/or denied claims (uncompensated care). Sustained access to care depends on recovering the aggregated cost of all of these elements through reimbursement from insurance carriers and/or patient cost-sharing participation.

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Reimbursement Disparity

The current and increasing challenge for healthcare providers is reimbursement from insurance carriers for identical services varies widely from zero to full billed charge depending on the insurance carrier's medical necessity policies, allowed coverage amounts, and other factors that appear to be arbitrary and unpredictable. This reimbursement disparity creates cash flow volatility and uncertainty for healthcare providers. Such volatility creates risk in maintaining stable access to care.

This reimbursement disparity challenge is made worse by low compensation from the Centers for Medicare and Medicaid Services (CMS). Medicare and Medicaid typically pay well below provider cost. The average Medicare payment for an IONM procedure covers only about 15% of what it costs ARHH to provide that service. Medicaid compensation is lower than Medicare and many states provide no IONM coverage whatsoever.

Volume of Patients

Every healthcare provider has elements of fixed cost related to their practice. Such costs include wages, benefits, equipment, facilities, and administrative overhead. These fixed costs are typically paid for with money collected for services rendered to patients. The amount that needs to be collected to cover these costs depends heavily on the volume of patients that healthcare provider sees. If the healthcare practice has $1 million in fixed cost to remain available but only sees 1,000 patients per year, they would need to collect $1,000 per patient to cover their cost. However, if that same practice were able to see 4,000 patients per year, they would only need to collect $250 per patient to cover the same cost.

The volume of patients serviced by each practitioner of medicine varies greatly depending on variables outside the practitioner's control. One of the greatest factors is the rural nature of the community they serve. Rural healthcare facilities don't typically see as many patients as urban healthcare facilities, yet they face most of the same fixed costs required to keep their doors open. This drives up the cost per patient in rural facilities and requires higher reimbursement to meet the same fixed cost obligations as their urban counterparts.

One Size Does Not Fit All

The IONM industry is one example where network adequacy has failed and where benchmarking rates will result in the vast loss of access. In states where ARHH serves, only ten percent of IONM providers have in-network contracts. The remaining ninety percent of providers find it necessary to bill out-of-network because the in-network rates offered to providers do not cover their costs. If Congress passes legislation that sets a payment benchmark to the median in-network rate, the vast majority of IONM providers will not survive and most access to intraoperative neuromonitoring during invasive surgeries will be lost. This loss of access will result in worse patient outcomes and higher long-term cost of care.

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Capping healthcare compensation using median in-network rates or multiples of the Medicare fee schedule will result in disparate levels of compensation and coverage of cost, or lack thereof, between lines of service and markets. This would ultimately keep some markets whole and disenfranchise other markets, depending on existing network adequacy, variations in patient volume, and variations in cost structure. The complex nature of dissimilar healthcare markets and disparity of how much compensation is required to keep access in place cannot be addressed using simple benchmark equations. Therefore, if benchmarks are ultimately included in legislation there should be exemptions for markets with inadequate networks, low patient volume, or where Medicare rates do not contemplate the cost to deliver service.

Solutions

Virtually all insurance carriers and healthcare providers agree that prohibiting surprise balance billing must be accomplished through federal legislation. The area of disagreement is whether pricing benchmarks and/or binding arbitration should be incorporated into such legislation. Clearly, any disruption to existing reimbursement models creates risk that various points of healthcare access would be lost. Undoubtedly some healthcare practices and areas of healthcare will see their revenue decline below cost to operate.

In order to eliminate surprise billing AND protect existing access, the right solution would need to include a provision to resolve payment disputes between payers and providers. Such a provision should be binding arbitration and include the ability to aggregate like-kind claims to make the process more efficient. Without arbitration rights, providers have no recourse to mitigate insufficient funding to sustain their operations.

Payment benchmarks should be avoided as this would likely marginalize segments of healthcare that would experience significant disruption to their revenues. If payment benchmarks ultimately must be incorporated, it should be the greater of multiple options. Those options should include (1) a third quadrant percentile of the median in-network rate, (2) two hundred percent of the Medicare allowable rate, and (3) the median provider charge according to FAIR HEALTH, a non-profit national health claims database organization that tracks hundreds of millions of claims across all healthcare segments. Removing the ability for healthcare providers to charge sustainable rates puts our national healthcare system at risk of destabilization.

Conclusion

Should you wish to engage in dialogue about these matters I am certainly available to appear in-person. Thank you for the opportunity to share our perspectives and ideas about surprise billing solutions. We appreciate the Committee on Ways and Means diligence in dealing with this important matter as it will certainly impact the lives of tens of millions of Americans across our great land.